EXECUTIVE SUMMARY

CARE COORDINATION

Reducing Care Fragmentation in Primary Care

May 2013

For more information, see the Care Coordination Implementation Guide.

What

The complexity of modern medicine demands specialization, and high quality healthcare must ensure that patients receive care from those people and institutions best trained and equipped to provide a service, whether it be a surgical procedure, a medical evaluation, support for lifestyle change, or financial advice. As a consequence, care often involves referrals from provider to provider and transitions from one facility to another. Referrals and transitions can be dangerous, frustrating, and expensive if not managed well. Reducing the risks of fragmentation is a central objective of the Patient-Centered Medical Home (PCMH) Model of Care.

Care coordination is a set of activities that minimizes the dangers of fragmentation by ensuring that all providers involved in a patient's care share important clinical information and have clear, shared expectations about their roles. To coordinate care, a primary care practice must develop relationships with key specialist groups, hospitals, and community agencies; create protocols to support successful referrals and transitions; and develop systems to support information transfer.

Why

Communication breakdowns between providers and facilities can lead to unnecessary hospitalizations, duplicate tests and procedures, medical and medication errors, and other problems. Care coordination reduces these risks. Care coordination also reduces healthcare costs by preventing avoidable hospitalization and emergency department (ED) use.

Implementation Overview

Assume Accountability

- Decide as a primary care practice to improve care coordination.
- Develop a quality improvement (QI) plan to implement changes and measure progress.
- Develop a tracking system. Design the clinic's information infrastructure to internally track and manage referrals/transitions including specialist consults, hospitalizations, ED visits, and community agency referrals.

Support the Patient

- Organize a practice team to support patients and families. Delegate/hire and train staff to coordinate referrals and transitions of care, and train them in patient-centered communication, such as motivational interviewing or problem solving.
- Assess patient's clinical, insurance, and logistical needs.
- Identify patients with barriers to referrals/transitions and help patients address them.
- Talk to the patient during the visit about recent care experiences in other facilities, especially hospitalizations or visits to the ED, behavioral health visits, or other specialty care. Also ask about medications prescribed during non-PCP visits.
- Follow-up with patients within three days of an ED visit or hospitalization. Educate patients about appropriate ED use depending on patient type: healthy with acute need (e.g., minor injury), chronically ill, or a high ED user who may have unmet care needs (e.g., mental health, substance abuse).

Develop Relationships and Agreements that Lead to Shared Expectations for Communication and Care

- Identify, develop, and maintain relationships with key specialist groups, hospitals, and community agencies. Focus on the providers and organizations referred to most frequently. Begin by building or enhancing relationships with these providers.
- Develop verbal or written agreements that include guidelines and expectations for referral and transition processes. Find common goals to work on collectively, assume all providers have the best intent, avoid confrontation, and focus on the system not the people.
- Make certain that referring and consulting providers agree on the purpose and importance of the referral, and the roles that each will play in providing care.
- Standardize the information in referral requests and consultation reports to ensure it meets agreed upon expectations.

Establish Connectivity

- Develop and implement an information transfer system and assign designated staff to help patients and their information get where they need to go.
- Investigate the potential of shared EHR or web-based e-referral systems; if not available, set up another standardized information flow process.
- Consider the four key elements of an effective information transfer system, whether electronic (e-referral system, shared EHRs, or health information exchange) or pencil and paper:
  - Established agreements about information needs and expectations are integrated in the system.
  - The system helps ensure that requisite information is transmitted to the correct destination(s).
  - Key milestones in the referral/consultation process can be tracked.
  - Referring providers and consultants can efficiently communicate with each other.

What Progress Looks Like: PCMH-A Level A

The PCMH-A is a self-assessment tool to help practices understand their current level of "medical homeness," identify opportunities for improvement, and track their progress toward practice transformation. It is also a learning tool that can help start conversations within a practice about patient-centered care. The PCMH-A is scored on a 1–12 scale, which is divided into four levels (D, C, B, and A). A "Level A" item score indicates that most or all of the critical aspects of the key change addressed by the item are well established in the practice. An overall Level A score indicates that the practice has achieved considerable success in implementing the key design features of the PCMH.

Level A PCMH-A Items

For more information, see the Patient-Centered Medical Home Assessment (PCMH-A).

31. **Medical and surgical specialty services…**are readily available from specialists who are members of the care team or who work in an organization with which the practice has a referral protocol or agreement.

32. **Behavioral health services…**are readily available from behavior health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.

33. **Patients in need of specialty care, hospital care, or supportive community-based resources…**obtain needed referrals to partners with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs.

34. **Follow-up by the primary care practice with patients seen in the Emergency Room or hospital…**is done routinely because the primary care practice has arrangements in place with the ER and hospital to both track these patients and ensure that follow-up is completed within a few days.

35. **Linking patients to supportive community-based resources …**is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person.

36. **Test results and care plans…**are systematically communicated to patients in a variety of ways that are convenient to patients.

Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

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